Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3789AGC	A. BUILDING _____ B. WING _____	07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERNADETTE CARE HOME 2	6601 W HAMMER LANE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of the annual State Licensure survey conducted in your facility on 7/11/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 8 Residential Facility for Group beds for elderly and disabled persons, and/or persons with mental illnesses. Three beds are licensed for Category I residents and 5 beds are licensed for Category II residents.. The census at the time of the survey was 4 Category I residents and 3 Category II residents. Seven resident files were reviewed and 4 employee files were reviewed. Two closed resident files were reviewed. There were two complaints investigated during the survey: NV00015696 - Substantiated without deficiencies. NV00016558 - Unsubstantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	Y 000	Acceptable Plan of Correction 10/7/08 DeDe Price, HFS II	
Y 103 SS=F	449.200(1)(d) Personnel File - NAC 441A NAC 449.200 1. Except as otherwise provided in subsection 2,	Y 103		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Owner TITLE 9/28/08 (X6) DATE

Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3789AGC	A. BUILDING _____ B. WING _____	07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERNADETTE CARE HOME 2	6601 W HAMMER LANE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 103	Continued From page 1 a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by: NAC 441A.375 Medical facilities, facilities for the dependent and homes for individual residential care: Management of cases and suspected cases; surveillance and testing of employees; counseling and preventive treatment. 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have a: (a) Physical examination or certification from a licensed physician that the person is in a state of	Y 103		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3789AGC	A. BUILDING _____ B. WING _____	07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERNADETTE CARE HOME 2	6601 W HAMMER LANE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 103	Continued From page 2 good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. A medical facility shall maintain surveillance of	Y 103		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3789AGC	A. BUILDING _____ B. WING _____	07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERNADETTE CARE HOME 2	6601 W HAMMER LANE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 103	Continued From page 3 employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. Based on record review, the facility failed to ensure that 2 of 4 employees had received the required tuberculosis (TB) screening and had the required (TB) documentation in their personnel records. The facility failed to ensure that 2 of 4 employees had certification from a licensed physician that the employee was in a good state of health and free from (TB) or any other communicable disease documented in their personnel record. (employees #3,#4) Findings include: Employee #3's (hire date unknown) file did not contain documentation of a two- step TB test or documentation from a licensed physician that the employee was in a good state of health and free from TB or any other commmunicable disease. Employee #4's (hire date 2/25/08) file did not contain documentation that a two-step tuberculin screening test was performed or documentation from a licensed physician that the employee was in a good state of health and free from TB or any other communicable disease. Severity 2 Scope 3	Y 103	Y103 a) Employee #3's two-step TB test was completed 2007; a new 1st step and 2nd step was done Exhibit #1. Employee #4's two-step TB test was completed; a new 1st step and 2nd step was done though employee #4 filed a resignation on Sept 5, 2008 Exhibit # 2. b) All employees file will be reviewed quarterly to ensure all certifications, trainings and TB test is current. The administrator and owner will work together to monitor everything for compliance. c) Employee #4 July 24, 2008 Employee #3 Nov. 18, 2007	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3789AGC	A. BUILDING _____ B. WING _____	07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERNADETTE CARE HOME 2	6601 W HAMMER LANE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 105	Continued From page 4	Y 105		
Y 105 SS=F	449.200(1)(f) Personnel File - Background Check NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive. This Regulation is not met as evidenced by: NRS 449.179 Initial and periodic investigations of criminal history of employee or independent contractor of certain agency or facility. 1. Except as otherwise provided in subsection 2, within 10 days after hiring an employee or entering into a contract with an independent contractor, the administrator of, or the person licensed to operate, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing or a residential facility for groups shall: (a) Obtain a written statement from the employee or independent contractor stating whether he has been convicted of any crime listed in NRS 449.188 </NRS/NRS-449.html>; (b) Obtain an oral and written confirmation of the information contained in the written statement obtained pursuant to paragraph (a); (c) Obtain from the employee or independent contractor two sets of fingerprints and a written authorization to forward the fingerprints to the central repository for Nevada records of criminal history for submission to the Federal Bureau of Investigation for its report; and (d) Submit to the central repository for Nevada records of criminal history the fingerprints obtained pursuant to paragraph (c). 2. The administrator of, or the person licensed to	Y 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3789AGC	A. BUILDING _____ B. WING _____	07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERNADETTE CARE HOME 2	6601 W HAMMER LANE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 105	Continued From page 5 operate, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing or a residential facility for groups is not required to obtain the information described in subsection 1 from an employee or independent contractor who provides proof that an investigation of his criminal history has been conducted by the central repository for Nevada records of criminal history within the immediately preceding 6 months and the investigation did not indicate that the employee or independent contractor had been convicted of any crime set forth in NRS 449.188 </NRS/NRS-449.html>. 3. The administrator of, or the person licensed to operate, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing or a residential facility for groups shall ensure that the criminal history of each employee or independent contractor who works at the agency or facility is investigated at least once every 5 years. The administrator or person shall: (a) If the agency or facility does not have the fingerprints of the employee or independent contractor on file, obtain two sets of fingerprints from the employee or independent contractor; (b) Obtain written authorization from the employee or independent contractor to forward the fingerprints on file or obtained pursuant to paragraph (a) to the central repository for Nevada records of criminal history for submission to the Federal Bureau of Investigation for its report; and (c) Submit the fingerprints to the central repository for Nevada records of criminal history. 4. Upon receiving fingerprints submitted pursuant to this section, the central repository for Nevada records of criminal history shall determine whether the employee or independent contractor has been convicted of a crime listed in NRS 449.188 </NRS/NRS-449.html> and immediately	Y 105		

Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3789AGC	A. BUILDING _____ B. WING _____	07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERNADETTE CARE HOME 2	6601 W HAMMER LANE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 105	Continued From page 6 inform the health division and the administrator of, or the person licensed to operate, the agency or facility at which the person works whether the employee or independent contractor has been convicted of such a crime. 5. The central repository for Nevada records of criminal history may impose a fee upon an agency or a facility that submits fingerprints pursuant to this section for the reasonable cost of the investigation. The agency or facility may recover from the employee or independent contractor not more than one-half of the fee imposed by the central repository. If the agency or facility requires the employee or independent contractor to pay for any part of the fee imposed by the central repository, it shall allow the employee or independent contractor to pay the amount through periodic payments. (Added to NRS by 1997, 442; A 1999, 1946) Based on interview and record review, the facility failed to ensure a complete background check was completed for 3 of 4 employees. (#2,#3,#4) Findings include: Employee #2 Employee #2's (hire date 6/07) file contained no evidence fingerprints were taken and sent to the Nevada repository. There was no evidence of results from the Nevada repository. Employee #2, during an interview in the afternoon of 7/11/08, indicated she had not completed her fingerprinting. Employee #3 Employee #3's (hire date unknown) file did not	Y 105	a) Employee # 2's fingerprint was taken last Aug. 15, 2008 and was sent to Nevada Repository Result was received by the facility already. Exhibit # 3a and #3b. b) Administrator and owner will monitor all files at least every 6 months. c) date report generated: 8/28/2008 * Employee # 3's was put in file! * Employee # 4 file a resignation last Sept. 5, 2008	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3789AGC	A. BUILDING _____ B. WING _____	07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERNADETTE CARE HOME 2	6601 W HAMMER LANE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 105	Continued From page 7 contain a written statement indicating whether the employee had been convicted of a crime. There was no documented evidence of results from the Nevada repository. Employee #4 Employee #4's (hire date 2/25/07) file lacked documented evidence that fingerprints were sent to the Nevada repository. There was no evidence of results from the Nevada repository. Severity: 2 Scope: 3	Y 105		
Y 178 SS=F	449.209(5) Health and Sanitation-Maintain Int/Ext NAC 449.209 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. This Regulation is not met as evidenced by: Based on observation the facility failed to ensure the interior of the premises were well maintained. Findings include: The ceiling tile in the kitchen over the sink was cracked and a ceiling tile over the counter was darkened with a large hole. Interview with the owner indicated that new tiles were being ordered.	Y 178	a) Facility's kitchen ceiling has been cleaned, fixed and painted. b) Administrator and/or owner will make sure that the facility's premises, interior, exterior are well maintained c) Aug. 1, 2008	

Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3789AGC	A. BUILDING _____ B. WING _____	07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERNADETTE CARE HOME 2	6601 W HAMMER LANE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 178	Continued From page 8 Severity 2 Scope 3	Y 178		
Y 936 SS=F	449.2749(1)(e) Resident file NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: NAC 441A.380 is hereby amended to read as follows: 441A.380 1. Except as otherwise provided in this section, before admitting a person to a medical facility for extended care, skilled nursing, or intermediate care, the staff of the facility shall ensure that a chest radiograph of the person has been taken within 30 days preceding admission to the facility. 2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing, or intermediate care shall: (a) Before admitting a person to the facility or home, determine if the person: (1) Has had a cough for more than 3 weeks; (2) Has a cough which is productive; (3) Has blood in his sputum; (4) Has a fever which is not associated with a	Y 936	Y 936 a) Resident # no. 65 TB and step was completed by Infinity hospice and was put in file. Exhibit #49/#46 b) Administrator and/or owner will make sure before admitting a resident, he is free of communicable disease and a step TB test should be done. c) July 29, 2008	10/2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3789AGC	A. BUILDING _____ B. WING _____	07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERNADETTE CARE HOME 2	6601 W HAMMER LANE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 936	Continued From page 9 cold, flu, or other apparent illness; (5) Is experiencing night sweats; (6) Is experiencing unexplained weight loss; or (7) Has been in close contact with a person who has active tuberculosis. (b) Within 24 hours after a person, including a person with a history of bacillus Calmette-Guerin (BCG) vaccination, is admitted to the facility or home, ensure that the person has a tuberculosis screening test, unless there is not a person qualified to administer the test in the facility or home when the patient is admitted. If there is not a person qualified to administer the test in the facility or home when the person is admitted, the staff of the facility or home shall ensure that the test is performed within 24 hours after a qualified person arrives at the facility or home or within 5 days after the patient is admitted, whichever is sooner. (c) If the person has only completed the first step of a two-step Mantoux tuberculin skin test within the 12 months preceding admission, ensure that the person has a second two-step Mantoux tuberculin skin test or other single-step tuberculosis screening test. After a person has had an initial tuberculosis screening test, the facility or home shall ensure that the person has a single tuberculosis screening test annually thereafter, unless the medical director or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. A person with a documented history of a positive tuberculosis screening test is exempt from skin testing and routine annual chest	Y 936		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3789AGC	A. BUILDING _____ B. WING _____	07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERNADETTE CARE HOME 2	6601 W HAMMER LANE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 936	Continued From page 10 radiographs, but the staff of the facility or home shall ensure that the person is evaluated at least annually for the presence or absence of symptoms of tuberculosis. 4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation, the staff shall not admit the person until a health care provider determines that the person does not have active tuberculosis. 5. If a test or evaluation indicates that a person has suspected or active tuberculosis, the staff of the facility or home shall not admit the person to the facility or home, or, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that, although the person has active tuberculosis, he is no longer infectious. A health care provider shall not certify that a person with active tuberculosis is not infectious unless the health care provider has obtained not less than three consecutive negative sputum AFB smears which were collected on separate days. 6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall	Y 936		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3789AGC	A. BUILDING _____ B. WING _____	07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERNADETTE CARE HOME 2	6601 W HAMMER LANE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 936	Continued From page 11 ensure that the person is treated for the disease in accordance with the recommendations of the Centers for Disease Control and Prevention for the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 8. The staff of the facility or home shall ensure that any action carried out pursuant to this section and the results thereof are documented in the person's medical record. Based on interview and record review, the facility failed to ensure Tuberculosis (TB) screenings were completed as per NAC 441A.380 for 1 of 7 residents (#6). Findings include: Resident #6, date of admission 8/10/07, had a one- step tuberculin screening dated 8/07. There was no further documentation regarding compliance with NAC 441A. During an interview, afternoon of 7/11/08, the caregiver and owner reported they thought the second step had been completed and would check with the company that completed the screening. Severity 2 Scope 3	Y 936		

Bureau of Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3789AGC	A. BUILDING _____ B. WING _____	07/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERNADETTE CARE HOME 2	6601 W HAMMER LANE LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y1010 SS=E	449.2764(1) MI Training NAC 449.2764 1. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after he becomes employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses. This Regulation is not met as evidenced by: Based on record review the facility failed to ensure 2 of 4 employees received the mandatory eight (8) hours of training concerning the care of residents with mental illness (#3,#4). Findings include: The personnel file for employes #3 (hire date unknown) and #4 (hire date 2-25-08) did not contain documented evidence of the mandatory eight hours of training for caregivers that provide care to persons with mental illness. Severity 1 Scope 3 2 2	Y1010	a) Employee #3 was scheduled to take the 8 hours training for Mental Illness on 8/2/2008. Employee #4 completed the training last July 12, 2008. b) Administrator and or owner will make sure that the required trainings will be done by the employees. Exhibit #5 c) Employee #3 Aug. 2, 2008 Employee #4 July 12, 2008	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.